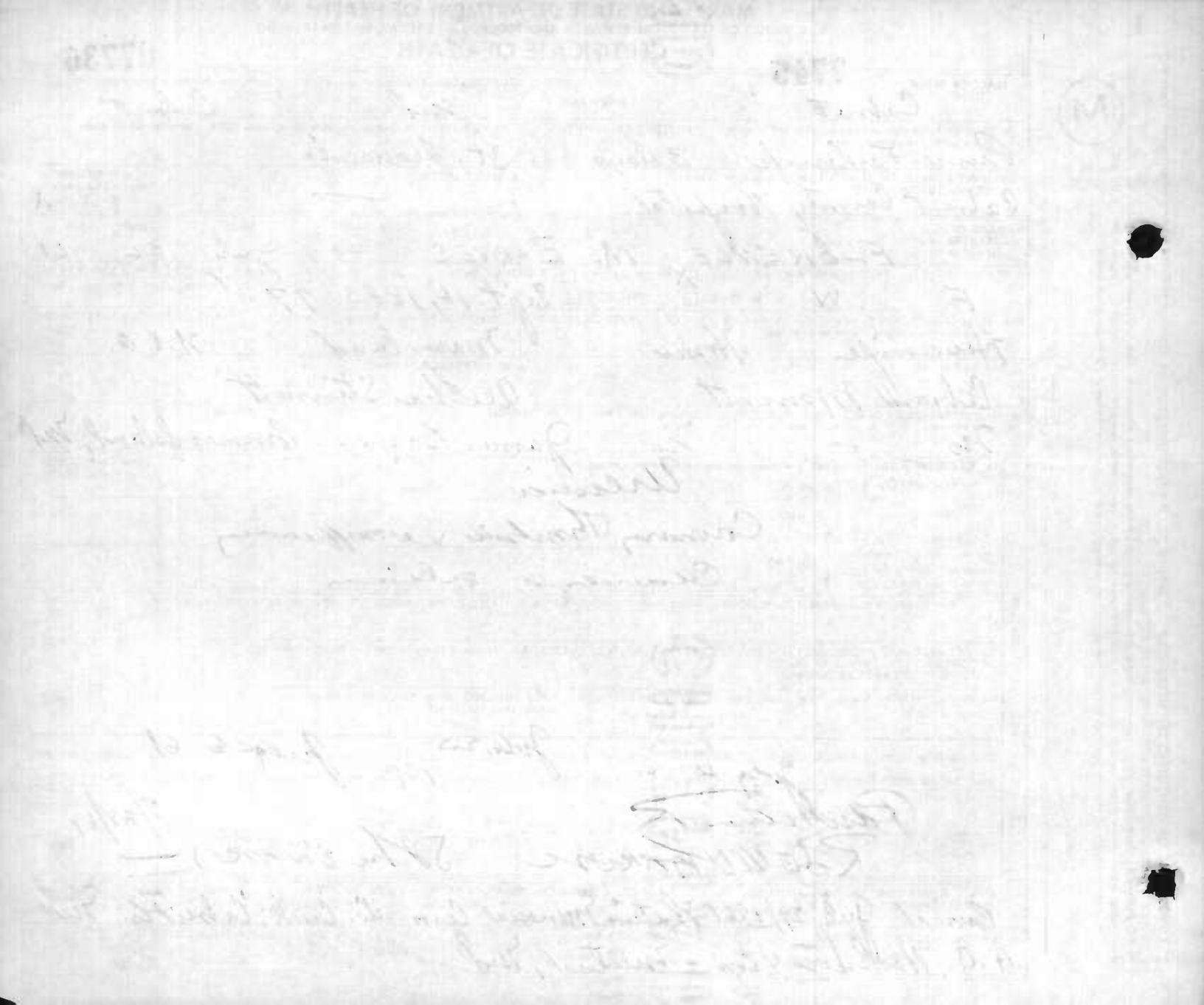


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07736

1. PLACE OF DEATH a. COUNTY		7745 Cabret MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md		b. COUNTY		Cabret		
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town)		Prince Frederick		c. LENGTH OF STAY IN 1b		3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town)		St. Leonard		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Cabret County Hospital		d. STREET ADDRESS		1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		Maryland		12. CITIZEN OF WHAT COUNTRY?		H. S. A.		
Housewife		Home										
13. FATHER'S NAME		14. MOTHER'S MARRIED NAME										
Cibrard Monnett		Aletta Stinnett										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address						
No		No		James Barnes - Broomes Island, Md								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span>												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												
420 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <span style="float: right;">(b)</span>												
DUE TO Coronary Thrombosis & emphysema												
DUE TO Generalized edema <span style="float: right;">(c)</span>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <span style="float: right;">19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></span>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
19												
21. I certify that (I) (this hospital) attended the deceased from July 26, 1961, to July 26, 1961, that (I) (we) last saw the deceased alive on July 26, 1961, and that death occurred at 10 P.M. from the causes and on the date stated above.												
22a. SIGNATURE		M.D.		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/26/61		
R. D. Villarino												
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		St. Leonard								
Burial		July 29, 1961		Waters Memorial Cem		W. Creek, Cabret, Md		(State)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town, or county)						
Burial		July 29, 1961		Waters Memorial Cem		W. Creek, Cabret, Md						
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR AUG 1 '61		25b. REGISTRAR'S SIGNATURE						
A. G. Harkness & Son - Mutual, Md.						Arthur S. Thomas						



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

07737

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1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Calvert</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>3 mos.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barstow</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) b. INSTITUTION <i>Calvert County Hospital</i>		d. STREET ADDRESS <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Bornes</i>		First	Middle	Last	4. DATE OF DEATH <i>July 30 1961</i>	Month	Day	Year		
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov. 4 1890</i>	9. AGE (In years last birthday) <i>70 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Owner</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>James Bowen</i>		14. MOTHER'S MAIDEN NAME <i>Agnes Buckler</i>		Address <i>Leroy H. Bowen, Prince Frederick, Md.</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <i>Yes WW2</i>		16. SOCIAL SECURITY NO. <i>217-36-5380</i>		17. INFORMANT <i>Cardiac Decompensation &amp; Edema</i>		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>416x</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i>		Rheumatic Heart Disease						
DUE TO <i>(b)</i>		DUE TO <i>(c)</i>		Rheumatoid Arthritis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.		22b. DATE SIGNED <i>7/31/61</i>								
22a. SIGNATURE <i>Page C. Jett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								
22c. PHYSICIAN'S NAME (Type) <i>PAGE C. JETT M.D.</i>		22d. ADDRESS <i>PRINCE FREDERICK, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 1, 1961</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Ashley Cemetery</i>		23d. LOCATION (City, town, or county) <i>Barstow, Calvert Co., Md.</i>		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>A.C. Harbeson Son, Mutual, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>AUG 2 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CE LIBRARY USE DATA

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7747

## CERTIFICATE OF DEATH

07738

## 1. PLACE OF DEATH

a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Burstown

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF  
DECEASED  
(Type or print)

Daniel

First

Middle

Last

4. DATE  
OF  
DEATH

July 15

1961

## 5. SEX

M

## 6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

## 8. DATE OF BIRTH

April 19 1879

9. AGE (In years)  
last birthday

82 yrs.

## IF UNDER 1 YEAR

Months Days

## IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Farm Owner

## 10b. KIND OF BUSINESS OR INDUSTRY

Farming

## 11. BIRTHPLACE (County &amp; State, or foreign country)

Calvert Co. Md

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

James Bowen

## 14. MOTHER'S MAIDEN NAME

Agnes Virginia Pucker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes give rank or date of service)

No

No

## 16. SOCIAL SECURITY NO. 17. INFORMANT

217-36-6594 Kenneth D. Bowen, Prince Frederick, Md.

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

610X

## DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

## (b)

## DUE TO

## (c)

Kenneth D. Bowen, Prince Frederick, Md.

INTERVAL BETWEEN  
ONSET AND DEATH

18 months

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

## 20c. TIME OF INJURY

## Month, Day, Year

Hour a.m.

19

p.m.

## 20d. INJURY OCCURRED

While  
at work Not While  
at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 2, 1959 to 7/15, 1961, that (I) (we) last  
saw the deceased alive on 7/15, 1961, and that death occurred at 7 A.M. from the causes and on the date stated above.

## 22a. SIGNATURE

George J. Scott

M.D.

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.22b. DATE  
SIGNED22c. PHYSICIAN'S  
NAME (Type)

## 22d. ADDRESS

George J. Scott, M.D.

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

## 23b. DATE THEREOF

## 23c. NAME OF CEMETERY OR CREMATORIUM

## 23d. LOCATION (City, town or county)

## (State)

## 24 FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

A. A. Harkness &amp; Son, Mutual Md.

## 25a. REC'D BY REGISTRAR

DATE JUL 18 '61

## 25b. REGISTRAR'S SIGNATURE

Charles S. Kraus



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

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 SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7748

Item 1, Film #1-306

2/5/62 200 Reg. Dist. No. 07739

1. PLACE OF DEATH  
 a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

7 Beach

c. LENGTH OF STAY IN lb

12 yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

a. STATE

Md

b. COUNTY

Calvert

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

7 Beach

d. STREET ADDRESS

1st & Davis

e. IS RESIDENCE  
 ON A FARM?  
 YES  NO

3. NAME OF  
 DECEASED  
 (Type or print)

First  
 Benjamin

Middle

Last  
 Hoover

4. DATE  
 OF  
 DEATH

July

24

1961

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

11 Jan 1910

9. AGE  
 (In years  
 last birthday)

57

YRS.

MONTHS

DAYS

HOURS

MIN.

10a. USUAL OCCUPATION (Give kind of work done  
 during most of working life, even if retired)

Carpenter

10b. KIND OF BUSINESS OR INDUSTRY

Construction work

10c. BIRTHPLACE (State or foreign country)

Indiana

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

225-16-0835

17. INFORMANT

Herbert Hoover 7 Beach Md

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a)

coronary heart disease

INTERVAL BETWEEN  
 ONSET AND DEATH

420.1 DUE TO

Conditions, if any, which  
 gave rise to immediate cause  
 (a), stating the underlying  
 cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
 PERFORMED?

YES  NO

20a. EXTERNAL CAUSE WAS  
 PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
 Hour a. m.  
 p. m.

Month

Day

Year

19

20d. INJURY OCCURRED  
 While  
 at work  Not while  
 at work

20e. PLACE OF INJURY (Home, farm,  
 factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause

ACTUAL  
 SIGNATURE

EXAMINER'S  
 NAME (Type)

22e. CHIEF MEDICAL EXAMINER

22f. ASSISTANT MEDICAL EXAMINER

22g. DEPUTY MEDICAL EXAMINER

DATE SIGNED

24 July 61

22b. BURIAL, CREMATION,  
 REMOVAL (Specify)

22c. DATE THEREOF

22d. LOCATION (City, town, or county)

22e. CEMETERY OR CREMATORIUM

22f. STATE

22g. CITY, TOWN, OR COUNTY

22h. STATE

22i. CITY, TOWN, OR COUNTY

22j. STATE

22k. CITY, TOWN, OR COUNTY

22l. STATE

22m. CITY, TOWN, OR COUNTY

22n. STATE

22o. CITY, TOWN, OR COUNTY

22p. STATE

22q. CITY, TOWN, OR COUNTY

22r. STATE

22s. CITY, TOWN, OR COUNTY

22t. STATE

22u. CITY, TOWN, OR COUNTY

22v. STATE

22w. CITY, TOWN, OR COUNTY

22x. STATE

22y. CITY, TOWN, OR COUNTY

22z. STATE

22aa. CITY, TOWN, OR COUNTY

22bb. STATE

22cc. CITY, TOWN, OR COUNTY

22dd. STATE

22ee. CITY, TOWN, OR COUNTY

22ff. STATE

22gg. CITY, TOWN, OR COUNTY

22hh. STATE

22ii. CITY, TOWN, OR COUNTY

22jj. STATE

22kk. CITY, TOWN, OR COUNTY

22ll. STATE

22mm. CITY, TOWN, OR COUNTY

22nn. STATE

22oo. CITY, TOWN, OR COUNTY

22pp. STATE

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22xx. STATE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

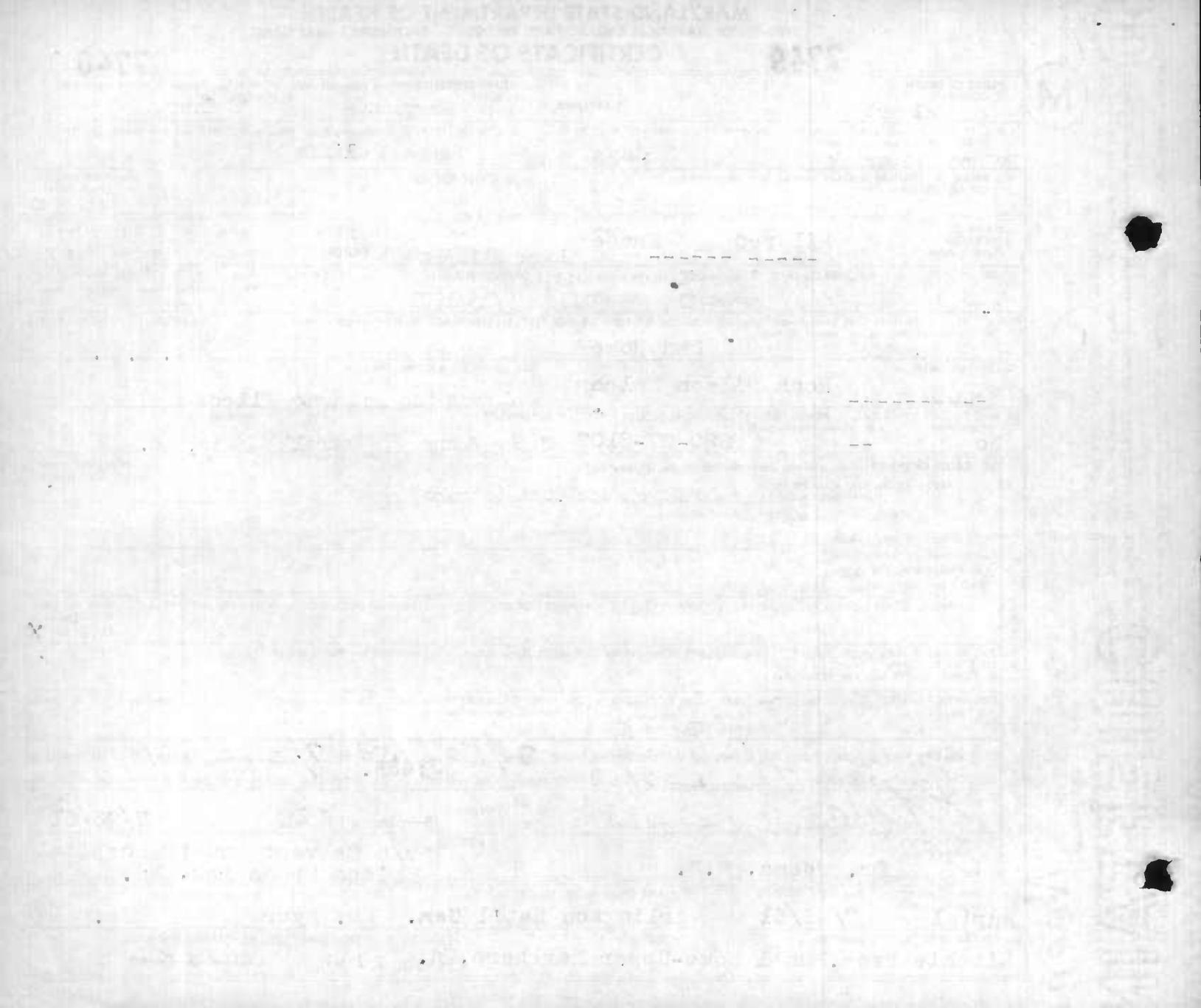
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7748

07740

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randall Cliffs		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mildred Irene Johns		First Mildred	Middle Irene	Last Johns	4. DATE OF DEATH July 23 1961	Month July	Day 23	Year 1961	
S. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/13/1901	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Wilson Welch		14. MOTHER'S MAIDEN NAME Noah Wilson Welch		15. INFORMANT James Johns		16. SOCIAL SECURITY NO. 220-07-8107			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17. INFORMANT James Johns			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/10/1961 to 7/22/1961 that (I) (we) last saw the deceased alive on 7/22/1961, and that death occurred at M, from the causes and on the date stated above.		22a. SIGNATURE Dr. Weems, M.D.		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7/23/61			
22c. PHYSICIAN'S NAME (Type) Dr. Weems, M.D.		22d. ADDRESS c/o Calvert County Hospital Prince Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/26/61		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cem.		23d. LOCATION (City, town, or county) Ft. Myer (State) Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'1 Home-Upper Marlboro, Md.		ADDRESS		25a. REC'D BY REGISTRAR DAUL 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07741

1. PLACE OF DEATH  
a. COUNTYCalvert  
Island Creek

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

?

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

EDWARD C. LICHENBERGER

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH7 Month  
14 Day  
Year  
1961

## 5. SEX

M

## 6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

WIDOWED  DIVORCED 

10/29/95

9. AGE (In years  
(If under 18, in months)  
yrs.)

65

10. IF UNDER 1 YEAR  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME

## 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Type, or unknown)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

782.4

## DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause lost.

(b)

## DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)

## Found dead in house where he lived alone

19. WAS AUTOPSY  
PERFORMED?YES  NO 20. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING   
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

## 20c. TIME OF INJURY Month, Day, Year

20d. INJURY OCCURRED  
While at work  Not while at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)20f. (City or town)  
(County) (State)21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find thatdeath resulted from: Natural causes  Accident , Suicide , Homicide , Undetermined cause 22. ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)23. BURIAL, CREMATION,  
REMOVAL (Specify)

## 24. DATE THEREOF

## 25. NAME OF CEMETERY OR CREMATORIAL

26. LOCATION (City, town, or county)  
(State)

## 27. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

## 28. REC'D BY REGISTRAR

## 29. REGISTRAR'S SIGNATURE

## DATE JUL 8 '61

## C. H. S. Trans

## VS. A15ME(5)

## 5M 9/55

## TO DEATH CERTIFICATE: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a certified copy of the death certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

## TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - GAITWIDGE 17  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME  
DEATH DATE

DEATH DATE

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07742

7751

## 1. PLACE OF DEATH

a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Calvert Beach

c. LENGTH OF STAY IN lb

4 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

## MEDICAL CERTIFICATION

## 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

b. COUNTY

Md

Calvert

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Calvert Beach

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

M

MacDonald

McDonald

4. SEX

F

6. COLOR OF RACE

W

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

WIDOWED DIVORCED 

July 1, 1896

9. DATE  
OF  
DEATHMonth  
JulyDey  
10Year  
1961

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County &amp; State, or foreign country)

13. FATHER'S NAME

Walter Eger

14. MOTHER'S MAIDEN NAME

Unknown

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes, give rank or rate and service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Louis D. MacDonald - Calvert Beach, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e)

1760

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last. (b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

13 months

Carcinoma of Uterus

INTERVAL BETWEEN  
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY  
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour

a.m.

p.m.

19

While at work

Not While at work

20d. INJURY OCCURRED While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from.....January....., 19....., to.....July....., 19....., that (I) (we) last saw the deceased alive on.....July 7....., 19....., and that death occurred at....., from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S  
NAME (Type)

Page C. Jett

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS.22b. DATE  
SIGNED

7-10-61

22d. ADDRESS

Prince Frederick, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Cremation July 11, 1961

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

Cedar Hill Crematory

23d. LOCATION (City, town or county)

Washington, D.C.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

A. A. Harkness &amp; Son - Mutual, Md.

ADDRESS

25a. REC'D BY REGISTRAR

JUL 12 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7752 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07743

1. PLACE OF DEATH

a. COUNTY

CALVERT

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

North Beach

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF  
DECEASED  
(Type or print)

First  
FORREST

Middle  
ROBERT

Last  
MULNIX

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED



WIDOWED

DIVORCED

8. DATE OF BIRTH

8/4/22

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SALESMAN

1Db. KIND OF BUSINESS OR INDUSTRY

ROBERT

11. BIRTHPLACE (State or foreign country)

Polo Ill

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

FORREST ROBERT MULNIX

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

YES

16. SOCIAL SECURITY NO.

17. INFORMANT

332-16-1809

14. MOTHER'S MAIDEN NAME

LAVOTTIE MURPHY

Address

411 CHAMBERS, WASH. D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Fatty infiltration of liver

581.1  
Conditions, if any, which  
gave rise to immediate cause  
(a), stealing the underlying  
cause last.  
(b)  
DUE TO  
(c)  
DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  or CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m.  
p.m.

2Dd. INJURY OCCURRED  
While at work  Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE

Russell S. Fisher

EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

7/12/61

22e. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR

ADDRESS

24e. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

144 Cook Inc. 1217 St. Paul St.

JUL 1 8 '61 Arthur S. Kraus

1960-1961

### fast action

46 [站内搜索](#)

## THE 1990 ADULT SURVEY

1  
X  
M X  
I  
O  
2  
VS. A15ME(5)  
5M 9/55

TO DEFEND MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**7753 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **07744**

1. PLACE OF DEATH a. COUNTY <b>Calvert</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W Beach</b>		c. LENGTH OF STAY IN 1b 1. LENGTH OF STAY IN 1b <b>W Beach</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>George Clippel Mindell</b>		d. STREET ADDRESS <b>W Beach</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mr George Clippel Mindell</b>		First <b>George</b>	Middle <b>Clippel</b>
		Last <b>Mindell</b>	DATE OF DEATH <b>7 16 1961</b>
4. SEX <b>W</b>		5. COLOR OR RACE <b>W</b>	6. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH <b>July 1918</b>		8. AGE (In years from birthday) <b>43 yrs.</b>	
9. IF UNDER 1 YEAR Months <b>0</b>		10. IF UNDER 24 HRS. Days <b>0</b>	
11. BIRTHPLACE (State or foreign country) <b>W. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Kleber Mindell</b>		14. MOTHER'S MAIDEN NAME <b>Mary Z. Cole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1943-1946-577-01-3796</b>	
17. INFORMANT Address <b>W. B. Mindell, M. B. Ward</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electric poison</b> DUE TO 322.2 Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>found dead in bed</b>	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>5:30 p.m. 7 16 1961</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Home</b>	
20c. TIME OF INJURY Hour <b>5:30 p.m.</b>		Month, Day, Year <b>7 16 1961</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>W. B. Mindell Calvert Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>		22. MEDICAL CERTIFICATION ACTUAL SIGNATURE <b>H. W. Ward</b>	
EXAMINER'S NAME (Type) <b>H. W. WARD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-19-61</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>Arlington Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hutchins Funeral Home Owings Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 19 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>O. G. Ward</b>	



1 Items 18-21 Film 292 MARYLAND STATE DEPARTMENT OF HEALTH  
 FOR STATE DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7754 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07745

1. PLACE OF DEATH  
 a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Prince Frederick

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Calvert County Hospital

3. NAME OF  
 DECEASED  
 (Type or print)

First  
 ISABELLA

Middle

Last  
 SMITH

4. DATE  
 OF  
 DEATH

Month  
 July

Day  
 16

Year  
 1961

5. SEX

Female

6. COLOR OR RACE

Colored

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

September 25, 1924

9. AGE (in years  
 last birthday)

36 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
 done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Maryland

13. FATHER'S NAME

Phillip Harris

14. MOTHER'S MAIDEN NAME

Nettie Giles

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
 (Yes, no, or unknown) (If yes give rank or date of service)

16. SOCIAL SECURITY NO.

218-30-4178

17. INFORMANT

Address

Asbury Smith, Owings Md

INTERVAL BETWEEN  
 ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a)

981X  
 Conditions, if any, which  
 gave rise to Immediate cause  
 (a), stating the underlying  
 cause last.

DUKTOX

(b)

DUE TO

(c)

Gunshot wound of neck with perforation of  
 left carotid artery and transection of spinal  
 cord

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
 PRIMARY  or CONTRIBUTING   
 CAUSE OF DEATH:

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Bystander at altercation during which gun was fired

20c. TIME OF INJURY Month, Day, Year

Hour **AM**  
 6:30 p.m. 7/16/61 19

20d. INJURY OCCURRED

While  Not While   
 at work  at work

20e. PLACE OF INJURY (Home, farm,  
 factory, street, office bldg., etc.)

Hilltop

20f. (City or town)

Owings

(County)

Calvert

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion  
 death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
 SIGNATURE

*Peter W. Rieckert*

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER  
 Associate Pathologist  
 DEMONSTRATOR OF MEDICAL  
 SCIENCE

DATE SIGNED

7/17/61

EXAMINER'S  
 NAME (Type)

Peter W. Rieckert, M.D.

Address (Street, city, town, or county)

22e. BURIAL, CREMATION,  
 REMOVAL (Specify)

Burial

22b. DATE THEREOF

7-20-61

22c. NAME OF CEMETERY OR CREMATORI

St. Edmonds

22d. LOCATION (City, town, or country)

Sunderland-

(State)  
 Md

23. FUNERAL DIRECTOR

ADDRESS

*Anthony E. Sewell, Prince Frederick*

24a. REC'D BY REGISTRAR

JUL 24 '61

24b. REGISTRAR'S SIGNATURE

*Albert S. Kline*



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07746

## 1. PLACE OF DEATH

a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Prince Frederick

c. LENGTH OF STAY IN lb

3 days

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Calvert

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Barstow

d. STREET ADDRESS

e. IS RESIDENCE

ON A FARM?

YES  NO 

064

064

## 3. NAME OF

(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATHMonth  
JulyDay  
29  
Year  
19 61

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED 

8. DATE OF BIRTH

12/23/73

9. AGE (In years  
lost birthday)  
yrs.

87

10. IF UNDER 1 YEAR

Months  
Days

11. IF UNDER 24 HRS.

Hours  
Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Farm Owner

10b. KIND OF BUSINESS OR INDUSTRY

Tanning

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Benjamin Stafford

14. MOTHER'S MAIDEN NAME

? Bowen

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

720

17. INFORMANT

Frank Stafford-Barstow, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

450

Mesentetic Thrombosis - Toxemia

INTERVAL BETWEEN  
ONSET AND DEATH

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

Cerebral arterio-sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19  
p. m.20d. INJURY OCCURRED  
White Not white  
at work  of work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 27, 1961, to July 29, 1961, that (I) (we) last  
saw the deceased alive on July 28, 1961, and that death occurred at 8:30 M, from the causes and on the date stated above.

22a. SIGNATURE

A. DeClancy

M.D.

ATTENDING  
PHYS.MED.  
DIRECTORSTAFF  
PHYS. 22b. DATE  
SIGNED  
7/29/6122c. PHYSICIAN'S  
NAME (Type)

R. De Vincenzo

22d. ADDRESS

5th Street, Leonardtown, Md.

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial July 31, 1961

23b. DATE THEREOF

Ashley Cemetery

23d. LOCATION (City, town, or county)

Barstow - Calvert Co., Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

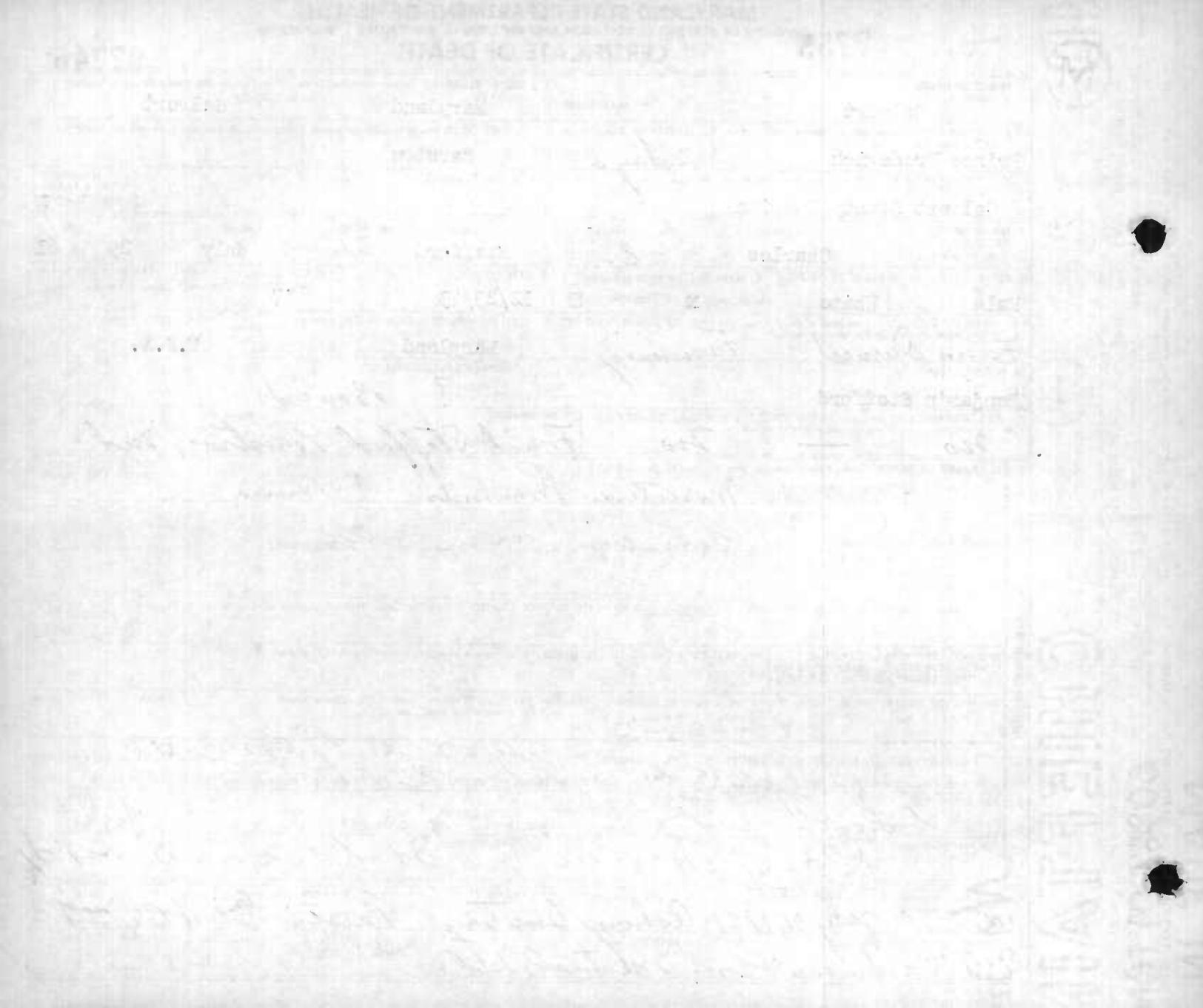
A. J. Harkness &amp; Son - Mutual, Md.

ADDRESS

25a. REG'D BY REGISTRAR  
ADG 1 '61  
DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Harkness



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7756

## CERTIFICATE OF DEATH

Reg. Dist. No.

07747

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Calvert Beach</i>		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b <i>1 week</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>510 - 7th Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Sarah Elizabeth Sullivan</i>		First <i>Sarah</i>	Middle <i>Elizabeth</i>			
4. DATE OF DEATH <i>7 6 1961</i>		Month <i>July</i>	Day <i>6</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>Nov 18 1879</i>		9. AGE (In years from birthday) yrs. <i>81</i>	10. IF UNDER 1 YEAR Months <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>in our home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Edward Johnson</i>				
14. MOTHER'S M AIDEN NAME <i>Julia Ruckells</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				
16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT <i>Mrs. M. E. Davis, N. Beach Way</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>782.4</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cigarette</i>		DUE TO (c) <i></i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had drunken about 12 hrs</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>				
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/> <i></i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from alive on <i>7/6/61</i> , and that death occurred at <i>3:45 P.M.</i> , from the causes and on the date stated above.		ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. ADDRESS (Street, city or town, state) <i>Owings Mill</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/8/61</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet</i>	22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Malley's Funeral Home Inc.</i>		ADDRESS <i>Mt. Rainier, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>JUL 10 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Khan</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7757 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07748

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the remains, prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
Calvert MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Prince Frederick		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
Herald Wayne Thompson		758 Silver Spring Ave.	
3. NAME OF DECEASED (Type or print)		First	Middle
Herald Wayne Thompson		First	Middle
Last		4. DATE OF DEATH	Month Day Year
Last		July 1 1961	Month Day Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/11/21
9. AGE (In years from birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	
40 yrs.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
Furnace fitter installer		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Unknown		Mrs. J.W. Thompson wife of	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
Yes		16. SOCIAL SECURITY NO. 17. INFORMANT	
WV11		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Set on left ear & neck	
(b) Drown			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Fall off boat and hit by propeller			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. 7/1/61		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Transit		Baltimore, Md. Calvert Co.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED	
ACTUAL SIGNATURE <i>H. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Transit- Burial 7/10/61		22c. NAME OF CEMETERY OR CREMATORIAL	
		22d. LOCATION (City, town, or county) (State)	
		Chicago, Illinois (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Warner E. Pumphrey, Inc.		8434 Georgia Avenue	
Raymond H. WSKA		Silver Spring, Maryland	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE JUL 5 '61		Arthur S. Kraus	

MANUFACTURED STATE DEPARTMENT OF MARSHAL-ADMINISTRATIVE

WEAPONAL EXAMINERS CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7758

## CERTIFICATE OF DEATH

Reg. Dist. No. 07749

1. PLACE OF DEATH o. COUNTY <b>Calvert</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chesapeake Beach</b>	
3. NAME OF DECEASED (Type or print) <b>JULIA</b>		First <b>L.</b>	Middle <b>THORNTON</b>
4. DATE OF DEATH <b>July 27 1961</b>		Month <b>July</b>	Day <b>27</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>October 14, 1879</b>		9. AGE (In years lost birthday) <b>81 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>John C. Cunningham</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lloyd L. Thornton, Chesapeake Beach, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
420 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Huntingtown, Maryland</b>
20f. (City or town) <b>Huntingtown</b>		(County) <b>Maryland</b>	
(State) <b>Maryland</b>			
21. I certify that I attended the deceased from <b>7-20, 1961</b> , to <b>7-27, 1961</b> , that I last saw the deceased alive on <b>7-27, 1961</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>George J. Weems</b>		ADDRESS (Street, city or town, state) <b>Huntingtown, Maryland</b>	
DATE SIGNED <b>7/27/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 1, 1961</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>
22d. LOCATION (City, town, or county) <b>Smethport, Pennsylvania</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hutchins Funeral Home Owings Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 1 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Turner</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

AMERICAN STARCH COMPANY  
CERTIFICATE OF CREDIT

Mr.

AMERICAN STARCH COMPANY

1000 BROADWAY

NEW YORK CITY

U.S.A.

TELEGRAMS: "AMSTARCH", NEW YORK

TELEPHONE: "AMSTARCH", 5-32111

TELEGRAPH: "AMSTARCH", NEW YORK

TELEGRAMS: "AMSTARCH", NEW YORK

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TELEPHONE: "AMSTARCH", 5-32111

TELEGRAPH: "AMSTARCH", NEW YORK

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07750

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leads</i>			
3. NAME OF DECEASED (Type or print) <i>Edith Elizabeth Wheeler</i>		d. STREET ADDRESS <i>Mimosa Cove</i>			
4. DATE OF DEATH Month <i>7</i> Day <i>17</i> Year <i>1961</i>	5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>1895</i> 9. AGE (in years last birthday) <i>62</i> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Wash D.C.</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>B. Chandler</i>		14. MOTHER'S MAIDEN NAME <i>John Smyth</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Thomas Wheeler Leads</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>904</i> DUE TO <i>fractured leg</i>		9. AGE (in years last birthday) <i>62</i> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Wash D.C.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
DUE TO <i>fractured leg</i>		13. FATHER'S NAME <i>B. Chandler</i>		14. MOTHER'S MAIDEN NAME <i>John Smyth</i>	
DUE TO <i>fractured leg</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Thomas Wheeler Leads</i> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>904</i> DUE TO <i>fractured leg</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <i>Fell at home</i>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		22. TIME OF INJURY Month, Day, Year Hour o. m. <i>May 1961</i>	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland		24. DATE THEREOF <i>7/20/61</i>		25. NAME OF CEMETERY OR CREMATORIALY Rock Creek Cemetery	
26. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		27. LOCATION (City, town, or county) <i>Washington D.C.</i>		(State)	
28. EXAMINER'S NAME (Type) <i>H.W. WARD</i>		29. ADDRESS <i>8434 Georgia Avenue Silver Spring, Maryland</i>		30. REC'D BY REGISTRAR <i>JUL 19 '61</i>	
31. MEDICAL CERTIFICATION		32. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		33. DATE SIGNED <i>7/17/61</i>	

TO DEATH CERTIFICATE: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

REPUBLICAN STATE GOVERNMENT OF HAITI - GOVERNMENT OF  
THE HIGGIE D'CHAMBERS CIRCUIT OF BEAUMARIS

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